REQUEST FOR HEARING/AGENCY ACTION

NAME OF PROVIDER/PATIENT OR CLIENT/APPLICANT REQUESTING HEARING:

NAME:_____
ADDRESS: _____

_____

Social Security Number: ____/____/____ Client I.D. or Provider # (if known)_____

Date of Service (if known) _____ Medicaid program_____

1. The relief or action sought from the agency (the reason you are requesting a hearing) is: _____

_____

_____

2. The facts and reasons forming the basis for relief of agency action (the reasons you believe you are entitled to a hearing) are:

_____

_____

3. The names and addresses of all persons to whom you are sending a copy of this request for a hearing:

Name: _____ Address: _____

_____

Name: _____ Address: _____

_____

PLEASE ENCLOSE A COPY OF THE DENIAL NOTICE THAT CAUSED YOU TO REQUEST THIS HEARING. THIS IS VERY IMPORTANT. WITHOUT THIS INFORMATION YOUR HEARING COULD BE DELAYED.

THIS REQUEST MUST BE FILED WITH THE DIRECTOR'S OFFICE/FORMAL HEARINGS, DIVISION OF HEALTH CARE FINANCING WITHIN ____ DAYS OF THE DATE A DENIAL NOTICE IS ISSUED. (90 days for financial eligibility, 30 days for provider requests and anything other than financial eligibility.) A COPY OF THIS REQUEST MUST BE MAILED TO EACH PERSON KNOWN TO HAVE A DIRECT INTEREST IN THE REQUESTED AGENCY ACTION.

IF YOU WILL BE REPRESENTED BY AN ATTORNEY, THE ATTORNEY MUST FILE A NOTICE OF APPEARANCE IMMEDIATELY. If the Division of Health Care Financing does not receive notice at least ten calendar days before any scheduled hearing that an attorney for the petitioner will be present, the hearing may be rescheduled.

Attorney Representation? YES NO (circle)
NAME OF ATTORNEY/REPRESENTATIVE _____

ADDRESS: _____

_____PHONE #: _____

_____ _____
Please print name of person requesting hearing Phone #

_____ _____
Signature of person requesting hearing Date

SEND REQUEST TO: DIRECTOR'S OFFICE/FORMAL HEARINGS
DIVISION OF HEALTH CARE FINANCING
P.O. BOX 143105
SALT LAKE CITY UT 84114-3105
FAX #: 801-538-6412